Last revised 4/23/02

ANMC Chronic Pain Program
Agreement for Long-term Use of Opioid Pain Medications

Opioid poin medications such as morphine, oxycodone, and codeine are some of the strongest known pain relievers. These medicines may be very helpful for some patients with chronic poin. Some patients say they are able to do more activities when they take these medicines. Most people also say they get a great deal of relief from their pain but do not get complete pain relief.

When I sign this paper I am saying that I understand that taking these opioid medications over a long period of time may cause some side effects. These opioid pain medications could decrease my ability to concentrate and think clearly, though this side effect usually decreases in time. Other side effects may include constipation, dizziness, itching, nausea, and difficulty passing urine. If I already have any of these problems, I will tell my provider.

I know that taking these opioid pain medications for a long period of time may cause me to become dependent. That means that if I stop taking the opiaid pain medications suddenly, I could have withdrawal symptoms such as tearing, runny nose, difficulty sleeping, agitation, abdominal pain, and severe discomfort.

I also understand that taking these opioid pain medications over a long period of time may put me at risk for developing an addiction. This means that I could start thinking only about taking opioid pain medications or other drugs so that other important ports of my life, such as my family, friends, work, and health could suffer. I understond that people with addictions are often not aware of the signs of addiction. I know it is very important that my provider follows me closely to see whether I am developing an addiction. To make sure I do not become addicted, I know that my provider may need to check my urine for these opioid pain medications or other drugs. My provider may randomly ask me to bring all of my opioid poin medications to the clinic for a pill count between my scheduled appointments; then, I would be required to report to the clinic within 24 hours. My provider may also need to be in contact with my family members and/or friends, because the symptoms of addiction may be seen by others I know before I see them.

WOMEN: Taking regular doses of opioid pain medications during pregnancy may be harmful to growing babies. I know I am not pregnant now and I will make sure as best I can that I will not become pregnant while I am taking opioid pain medications.

Write your Initials beside the responses:

A. TH I will do my best to take my opioid pain medications exactly as my provider tells me. If I am not taking them as my provider tells me, I will contact my provider. I will not take more opioid pain medications than my provider tells me to.

(Patient ID Sticker Here)

Todd Allen
3-30-07
353602

B. [X] I will not share or sell any opioid pain medications with anyone else.

C. [X] I will not drink alcohol on days I am taking opioid pain medications. I will not use illegal drugs.

D. [X] If I feel tired or mentally foggy, I will not drive, operate heavy machinery, or serve in any capacity related to public safety.

E. [X] I will give a urine sample when my provider requests it, to test for opioid pain medications and other drugs, to help test for drug use and monitor for physical dependence or addiction. My provider may ask a clinic staff member (of the same gender) to observe me as I produce the specimen. If I decline, I agree to give a blood sample.

F. [X] I will bring all of my opioid pain medications to the clinic every time I come to the Family Medicine Clinic to see a provider so that a staff member can count the number of pills I have. This will help my provider know if I am taking the opioid pain medications in the right way. My provider or case manager may ask me to come to the clinic just for this purpose and I will be required to bring all my opioid pain medications to the clinic within 24 hours.

G. [X] I will allow my provider to talk to my family, friends, and/or people I work with, as identified in the Chronic Pain Program General Agreement, to help monitor my progress, as well as to look for early signs of addiction.

H. [X] If my provider recommends, I will see a special provider for the purpose of finding out whether I am developing an addiction to opioid pain medications.

I. [X] It is my job to call my provider at least 3 business days in advance of running out of my opioid pain medications. I understand that my provider will not be able to prescribe pain medication during evenings and weekends. My provider's partners may not provide me with refills by phone, especially at night or on weekends.

J. [X] I understand that in the beginning my provider will ask me to keep written notes about my pain and when I take my opioid pain medications. I will share these notes with my provider. This will help my provider to keep track of my medication use and how well the medication is working.

K. [X] My provider may not be able to renew my prescription if I do not bring required information and all unused opioid pain medications to each provider visit.

L. _____ I will not receive medications for my pain (such as opioid pain medications, sleeping pills, tranquilizers, stimulants, and illicit drugs) from anyone other than my regular provider or my provider's partners. If I have an emergency that requires more pain medication, I will call my provider's office first unless an emergency makes me to go straight to the emergency room. If this happens, I will tell the provider in the emergency room or hospital about my special arrangement for use of opioid pain medications. After the emergency is over I will tell my provider that I got pain medication from another provider.

M. _____ I will go to pain education classes. These classes will include information on how to measure my pain as well as non-drug pain control techniques. I must go to all of these pain education classes within 9 weeks after the start of treatment in order to continue to get my opioid pain medications.

N. _____ I will work with my provider and case manager in making a care plan at the end of the pain education classes . I will try very hard to meet the goals we set. I understand that the care plan will be reviewed and changed every 3 months and I will continue to work hard to meet the goals. I know I must be active in trying to meet these goals in order to keep getting my opioid pain medications.

O. _____ I will allow my provider to receive information from any other health care provider or pharmacist to evaluate for possible misuse or abuse of alcohol or other drugs. The aforementioned permission shall expire only upon written cancellation of this agreement.

P. _____ I will have all my opioid pain medications filled at the ANMC Pharmacy. I give my provider permission to contact all other pharmacies and physicians to request that they not provide me with any addictive opioid pain medications. This permission shall expire only upon written cancellation of this agreement.

Q. _____ I understand that if my opioid pain medications are lost, stolen, or destroyed, they will not be replaced until my next scheduled refill date.

R. _____ I understand if I chose to change my primary care provider, my medical care will be changed to the new primary care provider during a visit that includes myself, the new primary care provider and the primary care provider I am transferring from.

S. _____ I understand that my provider may slowly take me off opioid pain medications if my provider believes that the opioid pain medications are harming me or not helping me.

T. _____ I understand that if I do not follow this pain medication agreement my provider will continue to provide my healthcare, but, my provider may choose to slowly take me off my opioid pain medications. Opioid pain medications may not be part of my treatment plan and I may be designated as Maintenance Opioid Inelligible in which case no ANMC provider will prescribe maintenance opioid medications to me.

U. _____ **FOR WOMEN:** I will do everything I can do to avoid getting pregnant while I take these opioid pain medications. To the best of my knowledge I am not pregnant now.

Todd A. Allen, has voluntarily entered into this agreement for long-term pain management.

Todd Allen 1-11-05

1. Patient signature 3. Date 6. Provider Signature Date

For provider:

2. Patient signed agreement	Yes, patient signed .....1 Patient refused to sign.....2 Other_____.....3
4. Renewal date	
5. Patient given copy of contract	Yes No

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ANMC Chronic Pain Program
Patient Initial Assessment

Item	Question	Response
1	What is your name?	Name Todd Allen
2	What is your Medical Record Number?	Record # 3-30-67
3	What is the best phone number to reach you at?	Phone 337-8895
4	What is an emergency phone number to reach you at?	Emergency Phone 263-8340
5	What is your work telephone number?	Work Phone 834-6913
6	What is your birth date?	3 / 30 / 67 date month year
7	How old are you?	Age in years 35 yrs. 9 mo
8	Marital Status	Single.....1 Married.....(2) Divorced.....3 Widowed.....4 Domestic Partner.....5
9	Who is your primary support person? * Make sure this person is identified and a signed release has been obtained to contact this person on the "General Chronic Pain Agreement"	Name
10	What is the telephone number for your primary support person?	Phone
11	Who is your primary care provider?	Provider Maria Freeman
12	Who is your case manager?	Case Manager Sarah Carter
13	What is the most recent Prime MD Score? (retrieve from the Health Summary)	Score:
14	Date of most recent Prime MD score? (retrieve from the Health Summary)	Date:
15a	Location of Pain: On Figure 1, please shade the area(s) where the patient feels pain. Mark an "X" in the areas that hurt the most. *Provider: Please identify each separate pain complaint with letters (e.g., A, B, C_), in order from greatest to least, for later reference.*	Location A: Right side head Jaw joint area/in side ear area due to T.M.J. pain broken jaw

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15b	Location of Pain (see Diagram 1)	Location B: left side head Jaw Joint area
15 c	Location of Pain (see Diagram 1)	Location C: Right side head-ear area
15d	Location of Pain (see Diagram 1)	Location D: left side head-ear area
16	PIA Date (Today's Date)	
	For questions 16a through 16e, the patient rates the pain using either 0-10 numeric scale (where 0 = no pain or 10 = worst imaginable pain), or FACES Pain Scale. Please note which is used. Use FACES with children, non-English speaking or cognitively impaired individuals.	
16a	Pain as it is right now	Rating (0 to 10) 5
16b	Pain at its worst	Rating (0 to 10) 10
16c	Pain at its best	Rating (0 to 10) 2
16d	Pain on average during the last month	Rating (0 to 10) 6
16e	Most acceptable level of pain	Rating (0 to 10) 6
17	Frequency of pain flares during the last month	# flares in past month Est 16
18	Duration of pain flares during the last month 1-2 hrs - to 2-3 days	Duration of flares in past month 2-hrs to 2-3 days
	Overall, what is your pain like? You can use your own words, or the following words:	Word Descriptors:
19a	Aching, Sharp, Penetrating	19a_____
19b	Throbbing, Tender, Nagging	19b_____
19c	Shooting, Burning, Numb	19c_____
19d	Stabbing, Exhausting, Miserable	19d_____
	Gnawing, Tiring, Unbearable	
	Intermittent, Continuous	
20	What sorts of things make your pain feel better, or relieves the pain (for example: heat, rest, medicine)?	List: heat, rest, medication Laying on my back not my sides

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21	What sorts of things make your pain feel worse, or increases your pain (for example: walking, standing, lifting)?	List: long days of laborous work, ~~cold~~ cold-freezing-weather, traveling through MTNS.
22	When and how did your pain problem start (onset and duration)? Broken Jaw from an Auto/ pedestrian incident,	Hx of pain:
23	As far as you know, what is the cause of your pain (i.e., the diagnosis)? T.M.J.	Cause of pain: Broken Jaw,
24	Do you notice variations and rhythms in the pattern of your pain?	Variations and Rhythms in pain:
25	In regards to your pain, what providers (anywhere) have you seen? When did you see them? What did they do? *(For example: Doctor did physical exam, ordered tests, prescribed medication)*	Names of providers seen: Dr. Todd - Valdez AK Ph# 835-4811 - last visit Nov. month? Est.
25b1 25b2	Previous Primary Care Provider 1 Date of change	
25c1 25c2	Previous Primary Care Provider 2 Date of change	
25d1 25d2	Previous Primary Care Provider 3 Date of change	
26	What tests and studies have been done in regards to your pain (e.g., MRI, CT-Scan, X-Rays)← All. Reconstructive Surgery R. side mandible	Tests and studies done:
27	What clinics have you been to other than Family Medicine at ANMC in order to address your pain? Valdez medical clinic Valdez, AK Ph. (907) 835-4811	Orthopedics.....1 Neurology.....2 ADATT.....3 Mental Health.....4 Physical Therapy.....5 Women's Health Clinic.....6 Internal Medicine.....7 Complementary Medicine.....8 Traditional Healing Program.....9 Other (List_____).....10

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28a1	What medications have you taken in the past for your pain? Been the same	28a1 Medication Percocet
28b1	How effective has the medication been?	28b1 Effectiveness 7-8 (0=not effective; 10=extremely effective)
28c1	Comments: If prescribed outside of ANMC, please note the prescriber's name. Dr. Todd VMC, 835-4811	

28a2	What other pain medicotions have you taken in the past? Valium	28a2 Medication Valium
28b2	How effective has the medication been?	28b2 Effectiveness 7-8 (0=not effective; 10=extremely effective)
28c2	Comments: If prescribed outside of ANMC, please note the prescriber's name.	
28a3	What other pain medications hove you taken in the past?	28a3 Medication _____
28b3	How effective has the medication been?	28b3 Effectiveness _____ (0=not effective; 10=extremely effective)
28c3	Comments: If prescribed outside of ANMC, please note the prescriber's name.	

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28a4 28b4 28c4	What other pain medications have you taken in the past? How effective has the medication been? Comments: If prescribed outside of ANMC, please note the prescriber's name.	28a4 Medication _____ 28b4 Effectiveness _____ (0=not effective; 10=extremely effective)
28a5	Please list any over-the-counter medications you are currently taking.	28a5 List: advil, motrin
29a to 29r	Whether here at ANMC or in the community, what non-drug treatments have you received for your pain, and how effective have they been?	Technique and Effectiveness *Please rate on a scale of 0 – 10* *(0 = not effective;* *10 = extremely effective)* 29a Biofeedback.....1 _____ 29b Exercise.....2 _____ 29c Group Thx.....3 _____ 29d Distraction.....4 _____ 29e Tens Unit.....5 _____ 29f Bedrest.....6 _____ 29g Healing Hands.....7 _____ 29h Poking.....8 _____ 29I Blessings.....9 _____ 29j Imagination.....10 _____ 29k Psychotherapy...11 _____ 29l Heat/Cold.....12 _____ 29m Massage/Rubbing13 _____ 29n Dancing.....14 _____ 29o Cleansing.....15 _____ 20p Dream.....16 _____ 2oq Plant Medicine....17 _____ 29r Food Ceremony..18 _____

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	For the following questions (30a to 30 u) please indicate how your **pain has interfered with your daily functioning** *on a scale of 0 – 10 (0 = does not interfere; 10 = completely interferes)*	*(0 = does not interfere; 10 = completely interferes)*
30a.	Daily functioning	Rating (0 to 10) 2
30b	Quality of life	Rating (0 to 10) 5
30c	Enjoyment of life	Rating (0 to 10) 5
30d	General activity	Rating (0 to 10) .....
30e	Walking ability	Rating (0 to 10) 2
30f	Normal work routine	Rating (0 to 10) 2
30g	Stomach	Rating (0 to 10) 0
30h	Sleep	Rating (0 to 10) 2
30I	Appetite	Rating (0 to 10) 2
30j	Elimination (urination or bowel movements)	Rating (0 to 10) 0
30k	Breathing	Rating (0 to 10) 0
30l	Skin	Rating (0 to 10) 0
30m	Mood	Rating (0 to 10) 2
30n	Relations with people	Rating (0 to 10) 5
30o	Ability to concentrate	Rating (0 to 10) 2
30p	Hygiene	Rating (0 to 10) 0
30q	Sexual functioning	Rating (0 to 10) 5
30r	Physical appearance	Rating (0 to 10) 3
30s	Energy level	Rating (0 to 10) 3
30t	Other	Rating (0 to 10) .....
31a	**Economic Issues** Please rate your overall concern regarding **economic issues**, *such as housing, food, transportation, clothing, childcare, medical bills, prescriptions, insurance, etc.* Provider's Comments:	*(0 =no concern; 10 = greatest concern)* Rating (0 to 10) 2
31b	**Emotional Issues** Please rate your overall level of concern regarding **emotional issues**, *such as depression, frustration, anger, anxiety, panic attacks, mood swings, loss of motiv-ation, difficulty concentrating, psychotic, suicidal, fearful of medical procedures.* Provider's comments:	*(0 =no concern; 10 = greatest concern)* Rating (0 to 10) 0

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31c	**Social Support** **Please rate your overall concern regarding social support issues,** ***such as availability of support, communication with medical team, recent loss, role changes.*** Provider's Comments:	*(0 =no concern; 10 = greatest concern)* Rating (0 to 10) 0
31d	**Coping and Pain Management** Please rate your overall level of concern regarding your ability to cope or manage your pain, such as distraction, search for meaning, previous stress such as abuse having direct impact on current situation, counseling, medications, chemicals. Provider's Comments:	*(0 =no concern; 10 = greatest concern)* Rating (0 to 10) 2

Patient's Signature Todd Allen Date 1-11-03

Case Manager Signature _____ Date _____

Provider's Signature _____ Date _____

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Figure 1.